CENTRE FOR COLLABORATIVE HEALTH
The Oakville Clinic

1011 Upper Middle Road East, Unit A7, Oakville ON, L6H 4L2
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REFERRAL FORM FOR FUNCTIONAL MEDICINE

FAX this form and supporting documents to 905-849-6165

Please note that the clinic will contact the patient to set up an appointment date and time, and will also notify the referring doctor of these details.

Patient Information:

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

OHIP#: _____ Gender: _____

Doctor's Information:

Name: _____ Designation: _____

Phone: _____ Fax: _____

Date of Referral:

Reason for Referral:

Patient's Medical Information:	
Allergies	
Current Medications	
Current Supplements	
Past Medical History	

*Please attach any relevant labs/investigations to aid in the management of this patient.

Referring Doctor's Signature: _____